COMMUNITY MOBILIZATION AGAINST SUBSTANCE ABUSE AND VIOLENCE

2000-2001 ANNUAL REPORT

September 2002

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EXECUTIVE SUMMARY

Community Mobilization Against Substance Abuse and Violence has active community coalitions working throughout Washington. The Community Mobilization (CM) Program was established in 1989 by the Washington State Legislature to address the issues of substance abuse, violence, and related social ills through the organized and collaborative efforts of entire communities.

Community Mobilization provides vision. This report provides information and data about the functions and activities of the statewide CM Program in Washington's 39 counties. The CM Program's vision: **Community members participating in creating and sustaining healthy, safe, and economically viable communities, free from alcohol, tobacco, other drug (ATOD) abuse, violence, and all related social ills.** Local CM Coordinators make this a reality by pursuing CM's mission **to effectively address the problems of ATOD abuse and violence by promoting collaboration, cooperation, communication, commitment, and cultural competency.**

Community Mobilization is a local resource. Since the inception of CM, local CM Coordinators are recognized as their county's central resource point for all prevention efforts[1]. They are the first to be contacted when individuals or organizations have questions about substance abuse or violence prevention because they either have the answers or know the source of those answers[2].

Community Mobilization provides leadership. Successful community-based prevention programs build upon the efforts of a variety of grassroots and locally based organizations. CM promotes prevention efforts dependent upon a community commitment to values and attitudes consistent with a drug- and violence-free environment. CM leadership stimulates change and ensures that prevention efforts are culturally appropriate and effective. One of the most important prevention lessons learned throughout the last two decades is that ***prevention cannot be imposed from the outside; it must be led from inside the community to be effective***[3]. CM brings local leaders to the table.

Community Mobilization is based upon research. CM Programming uses the Communities That Care (CTC) model in promoting the positive development of children and youth, and the prevention of substance abuse and violence. CM is **based on rigorous research** from a variety of fields, including sociology, psychology, education, public health, criminology, medicine, and organizational development[4].

Community Mobilization is locally driven. The CM program requires an active governing board that represents the local community perspective. The board is involved in the development and implementation of the CM Program's substance abuse reduction strategy. At a minimum, each county must ensure that their board includes representation from education, treatment, law enforcement, local government, and other community organizations.

Community Mobilization is based upon partnerships. CM programs are directly involved in many networking efforts that have developed as a result of community representatives working together to

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[1]Developmental Research and Programs, Inc., *The Role Community Mobilization Programs Play Supporting County-Wide Efforts to Prevent Alcohol, Tobacco, Other Drug Use, and Violence,* Channing L. Bete Co., Inc., 2001, p. 12.
[2] Ibid., p. 15.
[3] Developmental Research and Programs, Inc., *Community Mobilization Evaluation, 2001 Final Report,* Channing L. Bete Co., Inc. 2001, p. 31.
[4] Ibid., p. 7.

share information. Examples include the Collaborative Needs Assessment, the Prevention Summit, the Washington State Survey of Adolescent Health Behaviors, Project *HomeSafe*, the Reducing Underage Drinking Coalition, the Washington Association for Substance Abuse and Violence Prevention, Tobacco Prevention, school partnerships, the National Network for Safe and Drug Free Schools and Communities, and the Governor's Council on Substance Abuse.

***Community Mobilization's success is supported by evaluation*[5].** Beginning in 1996 and continuing through 2000, the Office of Community Development (OCD) contracted with Developmental Research and Programs, Inc. (DRP) of Seattle, Washington, to conduct a comprehensive evaluation of the CM program. Several findings have emerged:

1. The CM projects are well integrated and often appear to be the center of each county's prevention services
2. CM organizations play a significant and visible role in each county's organizational prevention network
3. CM programs are tailored to fit their unique county settings and serve a broad cross section of adults and children
4. CM programs operate on shoestring budgets

In developing its outcome evaluation methodology, OCD has implemented pilot evaluations, has provided training and technical assistance to the local CM programs, and has provided ongoing support to the CM sites in implementing their outcome evaluation efforts. We have learned that:

1. High quality evaluation is possible and already taking place for local CM programs
2. Measurement instruments either already exist or are being fine tuned for local CM programs
3. Research designs have been developed for CM sites
4. Without continued oversight, local CM projects often cannot sustain the expense and resources needed to conduct their evaluation efforts

OCD staff continues to work with the CM Advisory Committee to develop and identify measurement tools appropriate for the local CM Programs. Such tools are needed to measure the two primary functions of local CM Programs:

1. To *mobilize*, or organize, their local communities
2. To reduce and prevent alcohol, tobacco, other drug abuse, and violence

Community Mobilization addresses emerging issues. While working on many different aspects of drug abuse and violence problems, CM Coordinators have found that new issues are constantly emerging. CM finds that it is in a unique position to help local communities and prevention partners respond to these issues, and state and local CM agencies regularly work together to develop a statewide approach. Emerging issues currently faced by CM are found within the Collaborative Needs Assessment, local and statewide networking, outcome measurement, methamphetamine impacts, and inadequate and unstable funding.

[5] Developmental Research and Programs, Inc., *The Role Community Mobilization Programs Play Supporting County-Wide Efforts to Prevent Alcohol, Tobacco, Other Drug Use, and Violence,* Channing L. Bete Co., Inc. 2001, p. 2.

INTRODUCTION

COMMUNITY MOBILIZATION WORKS FOR COMMUNITY CHANGE

Community Mobilization Against Substance Abuse and Violence has active community coalitions working in all 39 Washington counties. Community Mobilization (CM) Programs provide the catalyst and coordination necessary to bring community stakeholders and organizations together to develop strategies that counter substance abuse and violence. CM creates and builds on existing efforts to facilitate community change and provide healthy social development experiences for youth and families impacted by substance abuse and violence.

The CM Program was established in 1989 by the Washington State Legislature to address the issues of substance abuse, violence, and related social ills through the organized and collaborative efforts of entire communities. Established within the Washington State Office of Community Development (OCD), funding for CM comes from two sources, totaling $3.1 million per year, to ensure a statewide CM prevention presence. Washington State's dedicated Violence Reduction and Drug Enforcement (VRDE) account provides about $1.7 million per year; the Governor's portion of the federal Safe and Drug-Free Schools and Communities (SDFSC) Grant provides another $1.4 million.

This report provides information and data about the function and activities of the statewide CM Program in all of Washington's 39 counties. OCD staff and local CM Coordinators are enthusiastic and passionate about the ongoing successes enjoyed within the local CM Programs. The following pages will describe what the CM Program is really about; that is, *organizing local community members to prevent and reduce substance abuse and violence.*

We will also summarize the key evaluation findings from two recently published evaluation reports of the CM Program and discuss current issues faced by CM. We will describe the unique attributes of CM at the local level; i.e., how local CM Task Forces support treatment, law enforcement, and community organizing, and the unique voice of each community as it works to solve its own substance abuse and violence problems.

WHAT IS COMMUNITY MOBILIZATION?

Effective prevention of alcohol, tobacco, drug use, and violence requires communities to become organized and strongly motivated to meet the challenge. Successful prevention efforts require that a community find a structure and process that encourages a variety of independent, local organizations to cooperate effectively in the delivery of prevention services. In Washington State that structure and process is the CM model.

The CM Program's vision: **Community members participating in creating and sustaining healthy, safe, economically viable communities, free from alcohol, tobacco, other drug (ATOD) abuse, violence, and all related social ills.** Local CM Coordinators make this a reality by pursuing CM's mission **to effectively address the problems of ATOD abuse and violence by promoting: collaboration, cooperation, communication, commitment, and cultural competency.** CM funds and supports local community organizing efforts, services and projects directed toward ATOD, and violence reduction within every county in Washington State.

Since the inception of CM, local CM Coordinators are recognized as their county's central resource point for all prevention efforts[6]. They are the first to be contacted when individuals or organizations have questions about substance abuse or violence prevention because they either have the answers or know the source of those answers[7]. Their interconnections within their counties are major assets in linking organizations and services. In this capacity, CM Programs have become the cornerstone of prevention efforts throughout their counties. The CM Coordinators are the primary linkages between prevention organizations. They assist in the allocation of effort and resources, offer prevention expertise and consulting, ensure coordination of efforts, and generate momentum for passionately organized prevention communities. CM is the only prevention program in the state that requires local community mobilization as a prevention strategy. In some counties, the entire CM funding resource is dedicated to developing and nurturing this community organizing process[8].

Successful community-based prevention programs build upon the efforts of a variety of grassroots and locally based organizations. CM targets specific community needs identified through individual county collaborative needs assessments. Therefore CM promotes prevention efforts dependent upon a community commitment to values and attitudes consistent with a drug- and violence-free environment. Local CM leadership stimulates these changes and ensures that prevention efforts are culturally appropriate and effective. One of the most important prevention lessons learned throughout the last two decades is that ***prevention cannot be imposed from the outside; it must be led from inside the community to be effective***[9]. CM brings local leaders to the table to effectively spearhead this community commitment.

In each county, professionals and community members work together to develop their collaborative needs assessment to identify the highest substance abuse and violence risks prevalent among their

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[6] Developmental Research and Programs, Inc., *The Role Community Mobilization Programs Play Supporting County-Wide Efforts to Prevent Alcohol, Tobacco, Other Drug Use, and Violence,* Channing L. Bete Co., Inc., 2001, p. 12.
[7] Ibid., p. 15.
[8] Ibid., p. 1.
[9] Developmental Research and Programs, Inc., *Community Mobilization Evaluation, 2001 Final Report,* Channing L. Bete Co., Inc., 2001, p. 31.

communities and to select the protective factors they can implement in preventing these problem behaviors. This locally driven process involves a partnership of local staff from the following state-funded programs: CM, school districts, the Department of Social and Health Services/Division of Alcohol and Substance Abuse (DSHS/DASA), the Department of Health (DOH), Driving Under the Influence Task Forces, Community Health and Safety Networks, parents, concerned citizens, and other community organizations.

CM Programming uses the *Communities That Care (CTC)* model in promoting positive development of children and youth, and prevention of substance abuse and violence. CM **inclusively** engages all areas of the community in promoting healthy development. CM **proactively** identifies and addresses priority needs *before young people become involved in problem behaviors*, and targets early indicators instead of waiting until problems become entrenched in young peoples' lives. CM is **based on rigorous research** from a variety of fields, including sociology, psychology, education, public health, criminology, medicine, and organizational development[10]. CM is tailored to each community. Each local CM Program uses its own community's data-driven profile. This profile is developed from the county's collaborative needs assessment process to develop a comprehensive, long-range plan to strengthen existing resources and to fill identified gaps throughout their county.

Robin Posey, Sherry C. Wong, Richard F. Catalano, Ph.D., J. David Hawkins, Ph.D., Linda Dusenbury, Ph.D., and Patricia J. Chappel of Developmental Research and Programs, Inc. developed the *Communities That Care Prevention Strategies: A Research Guide to What Works*. In the early 1980's, J. David Hawkins and Richard F. Catalano also collaborated in conducting a review of thirty years of research on youth substance abuse and delinquency. This CTC model is the foundation of their work on risk and protective factor-focused prevention. Their approach is based on the simple premise that *to prevent a problem from happening, we need to identify the factors that increase the risk of that problem developing, and then find ways to reduce the risk.* This is the foundation upon which each local CM Program is built.

The uniqueness of CM's community organizing role, combined with the *Communities That Care* model and the county collaborative needs assessment process, results in prevention strategies that are locally driven. In this way, CM effectively addresses the specific substance abuse and violence reduction needs of local communities statewide.

Community Partnerships

Community Mobilization's success is largely due to the partnerships it has created. CM Coordinators have strengthened and expanded relationships over the years as they partnered with other community organizations to reduce substance abuse and violence.

The CM program requires an active policy board that represents the local community perspective. The board is involved in the development and implementation of the CM Program's substance abuse reduction strategy. At a minimum, each county must ensure that their board includes representation from education, treatment, law enforcement, local government, and other community organizations.

[10] Developmental Research and Programs, Inc., *Community Mobilization Evaluation, 2001 Final Report,* Channing L. Bete Co., Inc., 2001, p. 7.

CM programs are directly involved in many networking efforts that have developed as a result of community representatives working together to share information. Examples include:

Collaborative Needs Assessment

Locally, prevention professionals and community members are required by their funding sources to work together in developing a collaborative substance abuse and violence reduction needs assessment. This assessment assists the community partners to identify prevalent substance abuse and violence risk factors and to implement protective factors in prevention of these problem behaviors. This locally driven process involves partnerships among the following programs: CM, Office of Superintendent of Public Instruction (OSPI), DSHS/DASA, DOH, Community Health and Safety Networks, parents, concerned citizens, and community organizations.

The Washington Interagency Network (WIN) requested that, as a part of a larger State Incentive Grant (SIG) evaluation effort, the Collaborative Needs Assessment process be evaluated. Findings included:

- All counties completed a Collaborative Needs Assessment report.
- The assessment resulted in first-time collaboration for some counties. Some of the new workgroups established decided to continue meeting after the report was completed.
- The movement from collaborative assessment to collaborative planning occurred without a break in some counties.
- The vast majority of local partners went to great lengths to collect, analyze, and present data to their peers and community members.

Washington State Prevention Summit

Representatives from all areas of the substance abuse and violence prevention field come together every year in a statewide conference to share expertise and learn about innovative programs. This year's theme was ***"Connecting the Pieces."*** The conference workshops focused on collaborative efforts in prevention theory and science, practical application, innovations, policy and advocacy, systems development, taking research to practice, and advanced prevention science. Workshop tracks, which focused specifically on tobacco prevention, were available for college, school, community, and professional levels. CM Coordinators were both participants and presenters, highlighting their program practices and current strategies. This very successful annual collaborative event is well attended by members of the prevention field statewide.

Healthy Youth Survey (formerly known as Washington State Survey of Adolescent Health Behaviors)

Every two years, partners from the OSPI, DOH, DSHS/DASA, and OCD come together to jointly sponsor a statewide survey of youth health behaviors. The *Washington State Healthy Youth Survey* is given to school-aged students in grades 6, 8, 10 and 12. It gathers information concerning behaviors that may result in unintentional and intentional injury (e.g., seat belt use, fighting, and weapon carrying); physical activity; dietary behaviors; alcohol, tobacco, and other drug abuse; and

related risk and protective factors. Survey data is used as one source of information in developing county-level collaborative needs assessments.

Governor's Council on Substance Abuse (GCOSA)

GCOSA was established by executive order in 1994. CM is one of several key membership areas selected for representation. The Council works with state and local agencies and communities to develop common substance abuse reduction goals and priorities for the majority of prevention providers in the state. It also advises Washington State's Governor on substance abuse issues by providing policy, program, and research recommendations.

Project HomeSafe (Gun Safety Locks)

The Lieutenant Governor's Office partnered with CM and the Washington Association of Sheriffs and Police Chiefs (WASPC) to promote *Project HomeSafe* statewide. *Project HomeSafe* supports safe firearm handling and secure storage practices among all firearms owners. Free firearm safety kits, including gun-locking devices, are distributed. The Association of Lt. Governors, which sponsored *Project HomeSafe* nationally, approached CM as the ideal partner in assisting law enforcement in the organization, coordination, and promotion of the program in Washington State's local communities.

Washington Association for Substance Abuse and Violence Prevention (WASAVP)

As the need to strengthen advocacy to reduce substance abuse, violence, and their effects on the citizens and communities of Washington State became critical, CM Coordinators came together and created the *Washington Association for Substance Abuse and Violence Prevention*. These local organizers represented large, small, rural, and urban communities. To create WASAVP, they blended their ideas, strengths, experience and, most of all, compassion. The mission of WASAVP is "To unite prevention advocates in Washington State in order to create environments that support safe and healthy communities through the prevention of substance abuse and violence."

Washington State Community DUI / Traffic Safety Programs

Traffic Safety Programs promote safe driving in their respective communities and serve over 85 percent of our state's population. In many counties, CM works directly with, or serves as, these County Coordinators. Services include coordinating emphasis patrol activities, presentations to youth and communities, public information and education, organizing mock crashes, safe prom activities, DUI victim impact panels, and supporting statewide campaigns.

Washington State Coalition to Reduce Underage Drinking (RUAD)

The RUAD Coalition, which serves as the advisory committee to the RUAD Policy Council and, ultimately, to the Governor, provides local grant funds to reduce underage drinking. The State Coalition was chartered to provide policy input and implement guidance to the RUAD Program. CM is a Coalition member at both the state and local levels. As such, CM works with other state

agencies, community groups, law enforcement, and youth to systematically address underage drinking.

Department of Health / Tobacco Prevention

CM Coordinators play a large role in tobacco prevention. CM is involved with DOH boards in the facilitation of training, such as *Teens Against Tobacco Use* for students, and participation in public service announcements. In several counties, CM Coordinators are also the Tobacco Prevention Providers. They work closely with local schools, assisting Prevention/Intervention Specialists with materials needed for students and providing educational material for classroom teachers. In some counties, CM Coordinators serve on their county's tobacco coalitions, which are responsible for programs and strategies for use of tobacco settlement funding.

The National Network for Safe and Drug Free Schools and Communities

The passion reflected by the local CM Coordinators who created WASAVP was mirrored at the state level when representatives from many of the states' Safe and Drug Free Schools and Communities Program federal grant came together and formed the *National Network for Safe and Drug Free Schools and Communities* (Network). Comprised of state-level school and governor's-portion administrators, the Network meets twice a year in Washington, D.C., and consistently enjoys attendance from no less than 30 states. Attendees at Network meetings share program implementation issues and expertise, seek problem resolution, and work to ensure that information about the program's successes is communicated to all policy levels. State-level CM staff played an active role in the Network, assuring that the states had input into the recently passed program reauthorization.

School Partnerships

Partnership is the appropriate description for CM in the school system. Statewide, school referrals consistently make up no less than 43 percent of local CM participants, as reflected by local program activity reports. CM is considered by Prevention Specialists to be their main resource. CM offers services that include prevention education, video rentals, school notification regarding activities such as the state wide poster contest, assistance with activities such as the “Mock Crash”, providing classroom educational materials, data for grant writing, and availability to schools for any questions concerning prevention.

CM assists Middle School Coordinators with information concerning needs assessments, laws and regulations related to prevention, and new laws and/or concerns. A Middle School Coordinator’s focus is on parent and community involvement with their perspective schools, thereby making the relationship between themselves and CM of great importance.

COMMUNITY MOBILIZATION'S PROCESS EVALUATION EFFORTS

Process evaluation is the most basic form of program evaluation. It examines the formation, development, and operations of a program. It includes whom the program serves, what kinds of services are delivered, how material and personnel resources are allocated, and the effectiveness of the program's management.

The CM Program's process evaluation efforts are dynamic and continue to evolve. Local CM Coordinators must provide an annual action plan and timeline for all planned activities, and are required to submit semi-annual program activity reports (PAR forms) documenting their risk and protective-factor-based activities.

The Foundation of CM's Past Process Evaluation Efforts

In 1996, OCD contracted with Developmental Research and Programs, Inc. (DRP) to conduct a comprehensive evaluation of the CM program. A long-term process and outcome evaluation plan was developed and implemented. The evaluation was completed in 2001[11].

Two distinct process evaluation efforts were implemented. During 1996-98, basic information on program operations was provided. Then, a network analysis specifically investigating the community mobilizing functions of the local CM projects was conducted in 1999-2001[12].

Process Evaluation Goals

1. Document the current program operations
2. Continue the process of putting the CM Program on a sound research base
3. Develop recommendations for program improvement
4. Develop new data collection methods to relieve CM Coordinators of administrative burden and support ongoing process evaluation
5. Provide training on the purposes, methods, and benefits of evaluation

The CM projects proved to be well integrated within the county-level prevention community. They often are at the center of their county's prevention services. CM project activities routinely incorporate high levels of volunteer efforts from other county-level organizations and provide substantial help to other prevention agencies. They play a significant and visible role in county organizational networks. Evaluation activities have a broad audience beyond the CM staff and contractors. There are multiple stakeholders in CM evaluation projects. In addition, it was found that CM programs are heavily customized and tailored to fit their unique county setting. CM serves a broad cross section of Washington's adults and children.

We also learned that many CM programs conducted activities that were inherently difficult to evaluate. This aspect of evaluation was not fully appreciated at the start of the evaluation process.

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[11] Developmental Research and Programs, Inc., *Community Mobilization Evaluation, 2001 Final Report,* Channing L. Bete Co., Inc., 2001, p. 2.

[12] Developmental Research and Programs, Inc., *The Role Community Mobilization Programs Play Supporting County-Wide Efforts to Prevent Alcohol, Tobacco, Other Drug Use, and Violence,* Channing L. Bete Co., Inc., p. 9.

CM contractors operate on shoestring budgets. These limited budgets make it difficult for CM contractors to build sustainable and lasting programs.

Recommendations included:
- OCD continue to allow substantial local control in program design.
- OCD provide training and technical support for CM Coordinators in protective factors, measurement, and evaluation.
- OCD improve documentation of local prevention activities, and demonstrate their relationship to the risk and protective factor model.

The 2000-2001 Network Analysis[13]

Using a statistical technique called "network analysis," CM county prevention efforts were quantitatively measured. The central role played by CM in the countywide prevention process was examined.

Successful community based prevention programs build upon a variety of organizational efforts. They depend on the community's commitment to values and attitudes consistent with a drug- and violence-free environment. Effectively changing community attitudes and norms require local leaders to spearhead prevention efforts. Local leadership has more influence, and it ensures prevention efforts are culturally appropriate and effective. Prevention cannot be imposed from the outside—it must be led from inside the community to be effective.

The Community Prevention Infrastructure

The CM Program specifically addresses the need for communities to develop a locally based "community prevention infrastructure" (CPI) that supports a vigorous and coordinated prevention effort, reaching all segments of the community. This CPI is the natural outgrowth of a healthy community mobilization process. Some CM contractors dedicate all their resources to the development and nurturance of the local community mobilization process. These contractors do not provide any direct services to county residents – they are committed to reducing substance abuse and violence in the communities by strengthening their local CPI. An effective CPI supports prevention programs through a number of concrete methods:

- Helping local prevention organizations identify at-risk populations
- Introducing new prevention organizations to important community gatekeepers
- Helping prevention organizations accurately assess county resources and levels of service, and reduce duplication
- Assisting new programs in identifying effective prevention activities

Aspects of Network Analysis

Three characteristics of the social network comprised of prevention related organizations in the county were investigated: ***density***, ***organizational centrality***, and ***clique membership***. Results from each of the core survey items were analyzed to assess each of these characteristics (which are

[13] Developmental Research and Programs, Inc., *The Role Community Mobilization Programs Play Supporting County-Wide Efforts to Prevent Alcohol, Tobacco, Other Drug Use, and Violence,* Channing L. Bete Co., Inc., 2001.

described below). All three characteristics provide information on the relative strength of the network as a whole, and on the involvement and importance of the CM organization within the prevention network.

Results

Density Analysis

Specific to CM organizations, a clear pattern of results is evident in the density analyses. Results indicate that CM organizations are consistently rated higher on the density measure than the average prevention organization. The density measurement for the CM organizations that participated was 76 percent. This means that CM programs were recognized by three-fourths of the respondents, which is significantly higher than was found for the average prevention organization in the studied counties. CM organizations play a significant and visible role in the county prevention network.

Organizational Centrality

Organizational centrality measures the relationship between CM Contractors and other agencies within the community. It calculates the number of direct interconnections (or links) that an organization provides between other organizations. This measure is particularly sensitive to organizational operations that typically link different players within the prevention infrastructure. CM contractors are average, or above average, when compared to other prevention organizations in the county.

The centrality measure also captures events where an agency serves as an indirect link between two other organizations. In this case, CM plays a role in linking up organizations or brokering services.

Clique Membership

Results of the clique analyses mirror those of centrality analyses. The level of interconnectedness is inversely related to the intensity of the involvement. CM contractors are as involved, or more involved, than the average county prevention organization, as measured by the number of clique memberships.

Summary and Discussion

The results of this analysis indicate that county-level CM contractors play a prominent role in county-level prevention. Analysis results were favorable for the CM projects in each of the network analyses: density, organizational centrality, and clique membership. Favorable CM findings were consistently reported at the varying levels of coordination among county-level prevention organizations.

These results confirm that county-level CM contractors play an important role in the development and support of the county-level prevention infrastructure. CM maintains a very visible profile, one that stands above other county-level prevention organizations.[14]

[14] Developmental Research and Programs, Inc., *The Role Community Mobilization Programs Play Supporting County-Wide Efforts to Prevent Alcohol, Tobacco, Other Drug Use, and Violence,* Channing L. Bete Co., Inc. p. 15.

The Program Activity Report (PAR)

The Program Activity Report (PAR) was developed to provide primary process data. It was developed in cooperation with the Division of Alcohol and Substance Abuse (DASA), since many local providers receive funding from both agencies. This reduced the duplication of the reports required by both agencies.

Initially the PAR forms were scanned, collated, and analyzed by DRP. Results of each year's data can be found in the annual reports produced for those years. When it became clear that relying on an outside consultant to collate and analyze data would not be feasible in the long term, DASA and OCD began looking for other alternatives.

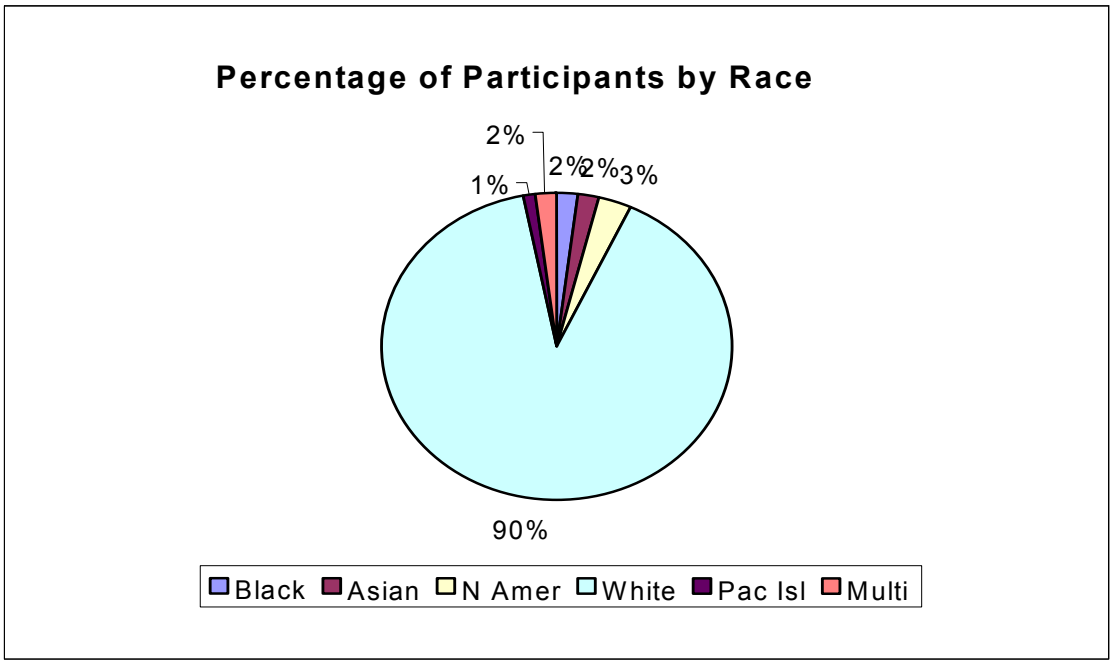
It was decided that a web-based PAR form might be feasible and solve a number of the problems inherent in the scannable tool. It is projected that pilot data entry will occur in early summer of 2002, and that a web-based PAR will be available for contractor use effective July 2002.

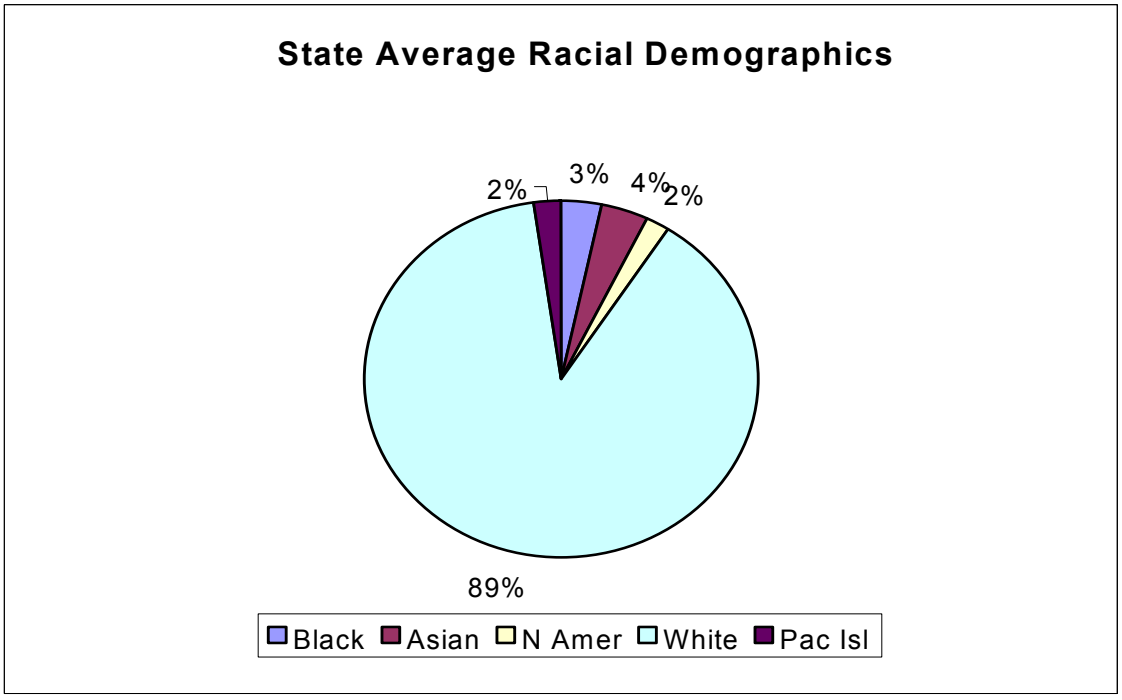
Program Activity Report Data for 2000 – 2001

Program Activity Reports for each service, program, or project are submitted semi-annually. Over the space of the program year (July to June), 664 reports were generated statewide. The following is information gleaned from those reports.

Unduplicated Participant count: 547,758 participants were provided with 122,125 direct hours of service in 42,319 distinct sessions.

Racial composition: CM served about the same racial minority members as the state average (90 percent white served by CM compared to 89 percent in the general population). While the individual categories did not show a substantial increase over the state average, 2 percent of the participants were multi-racial (a category for which the state has no data). Hispanics comprised 18 percent of the participants, in contrast to the state average of 6 percent. The gender ratio is 47 percent male and 53 percent female.

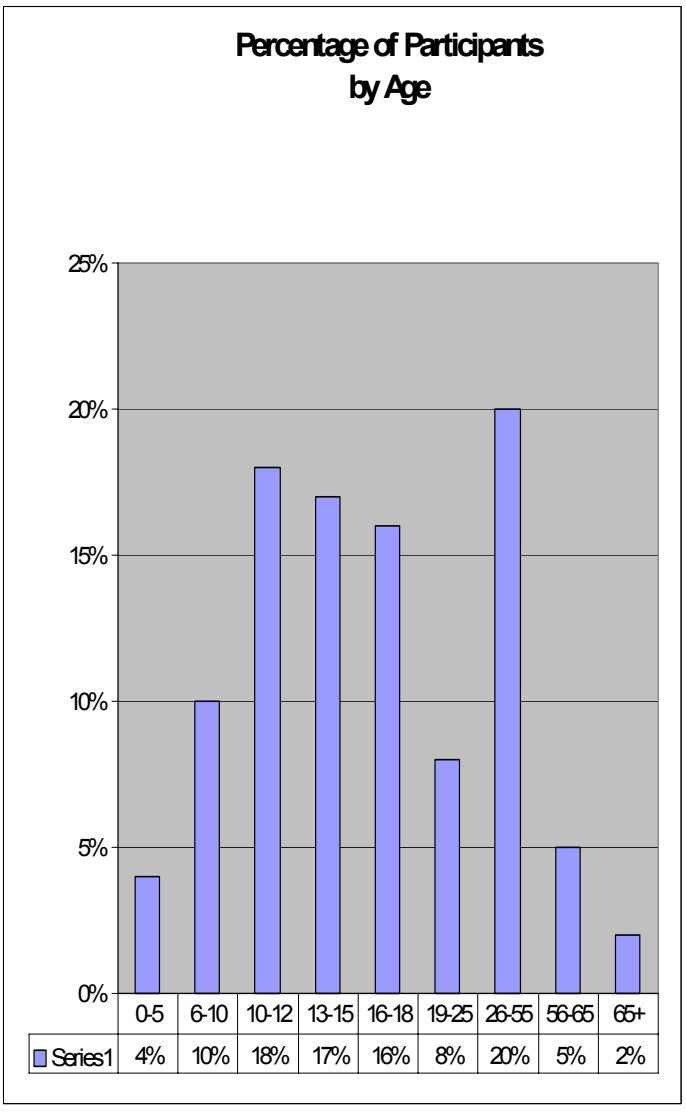


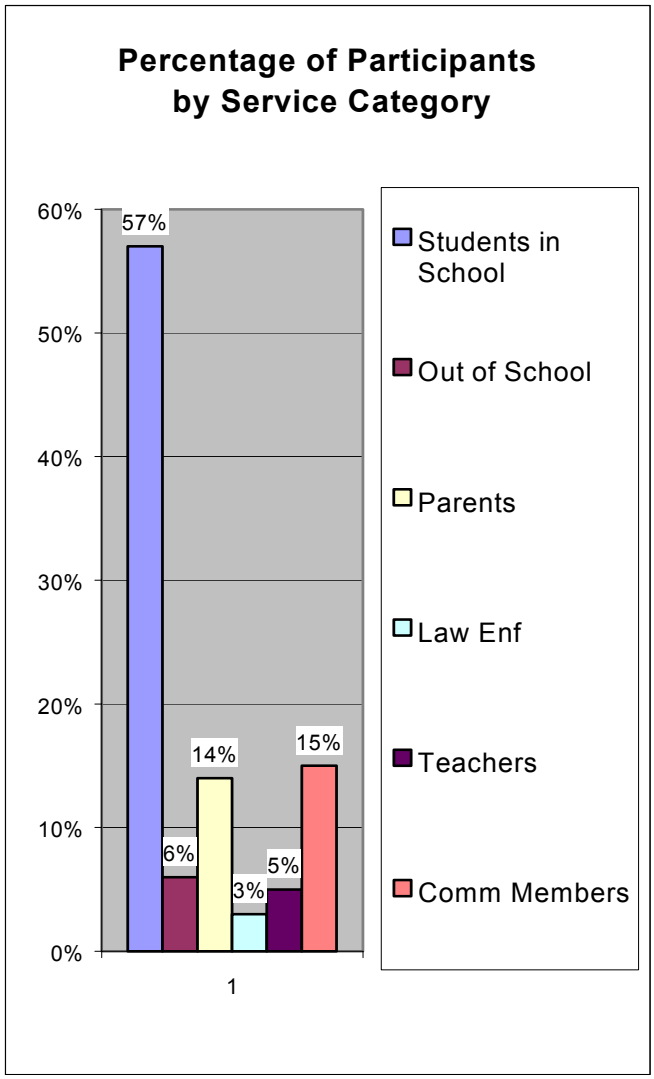


Composition by Age: The two largest groups of participants served were youth from the ages of 10 to 18 (51 percent) and adults 26-55 (20 percent). Fifty-seven percent of the participants were youth enrolled in school (all ages), while another 6 percent were youth not currently enrolled in school. These statistics show that the majority of the programs serve school-aged youth and enhance prevention activities or programs in the schools.

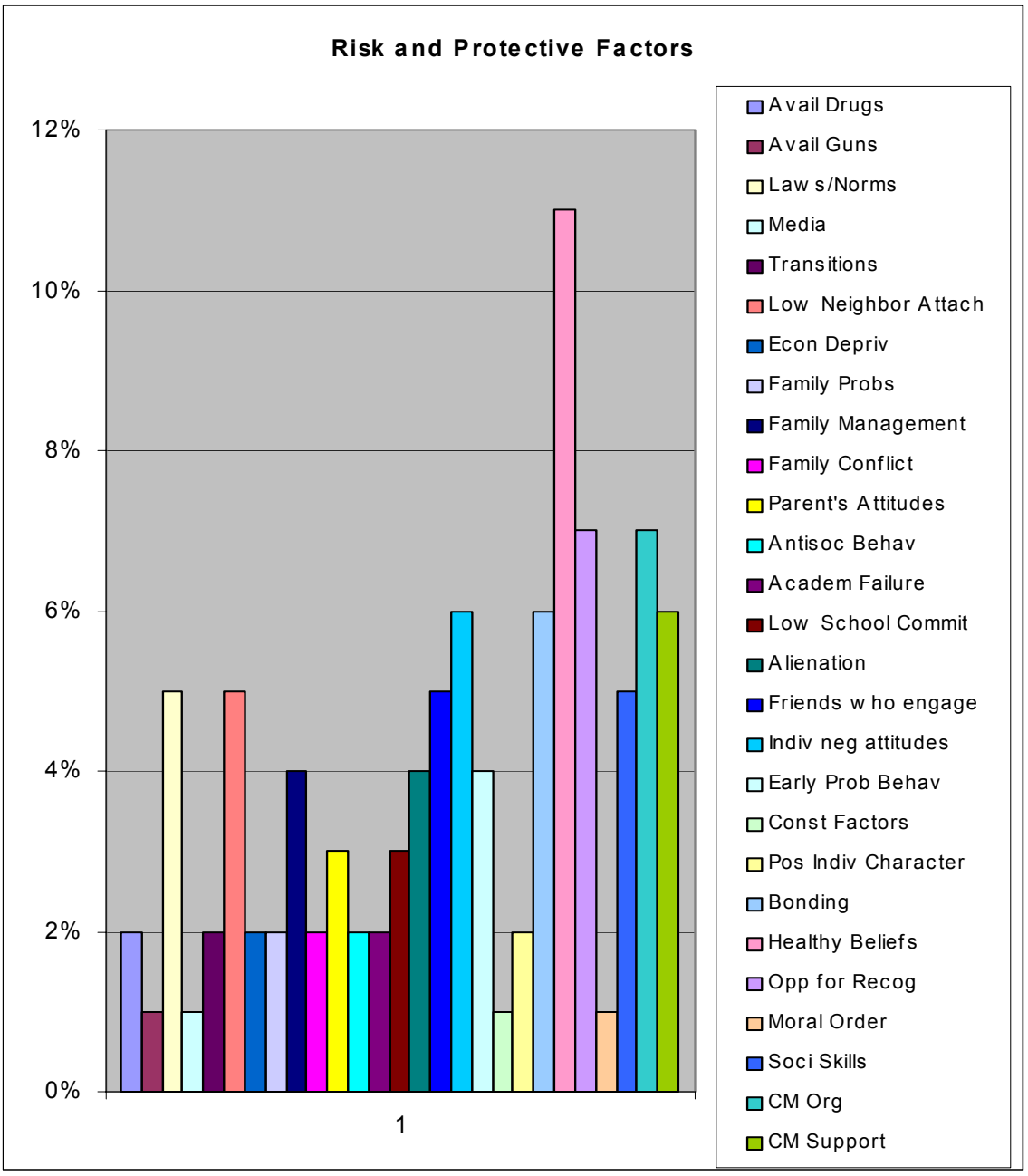
The adults in this category are primarily parents. This can be verified by comparing the percentage of parents served in the chart below: "Percentage of Participants by Service Category" (14 percent of total) with the chart: "Percentage of Participants by Age" (28 percent are between the ages of 19 and 55). The other approximately half of the adults include community members (15 percent), teachers (5 percent), and law enforcement (3 percent).

The second largest adult group of participants (15 percent of the total) is from the community. This is significant, since one focus shared by all CM contractors is working with communities to increase awareness and involvement in prevention activities.





Risk and Protective Factor Data: The CM model uses the Risk and Protective Factors as identified by Hawkins and Catalano in "Communities that Care." The PAR data showed that 44 percent of the programs were primarily intended to increase protective factors in their communities (the chart "Risk and Protective Factors by Domain"). Of these, the most frequently addressed protective factors were "Healthy Beliefs and Clear Standards (15 percent), followed closely by "Opportunities to build skills and receive recognition", and "Social Skills" (both of which showed 7 percent).



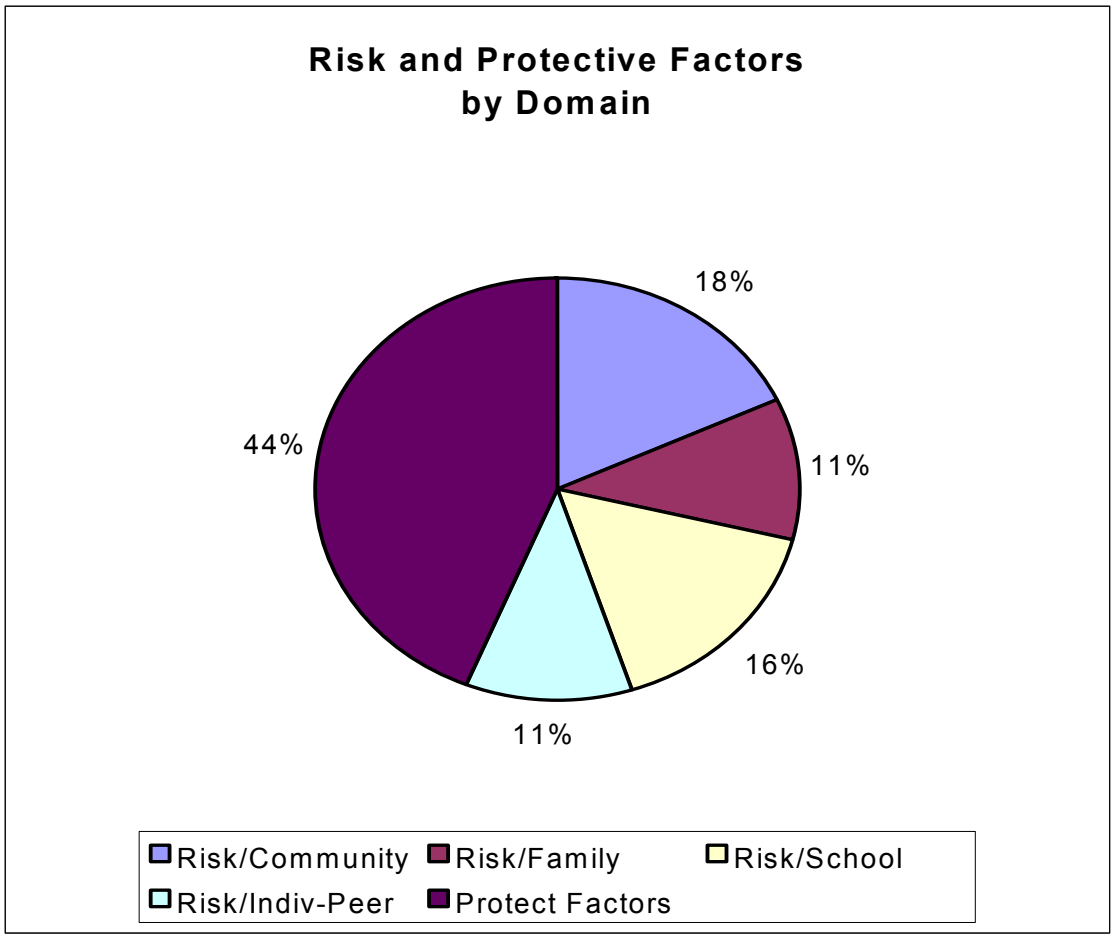
In the Risk Factor domains, the largest number of programs (18 percent) addressed Community risk factors, while Schools were second (at 16 percent), and Families and Individual/Peer both received 11 percent of the programming.

In the Community domain, ”Laws and Norms Tolerant of Substance Abuse and Violence”, and “Transitions and Mobility” were the highest categories (both received five percent of the overall programming).

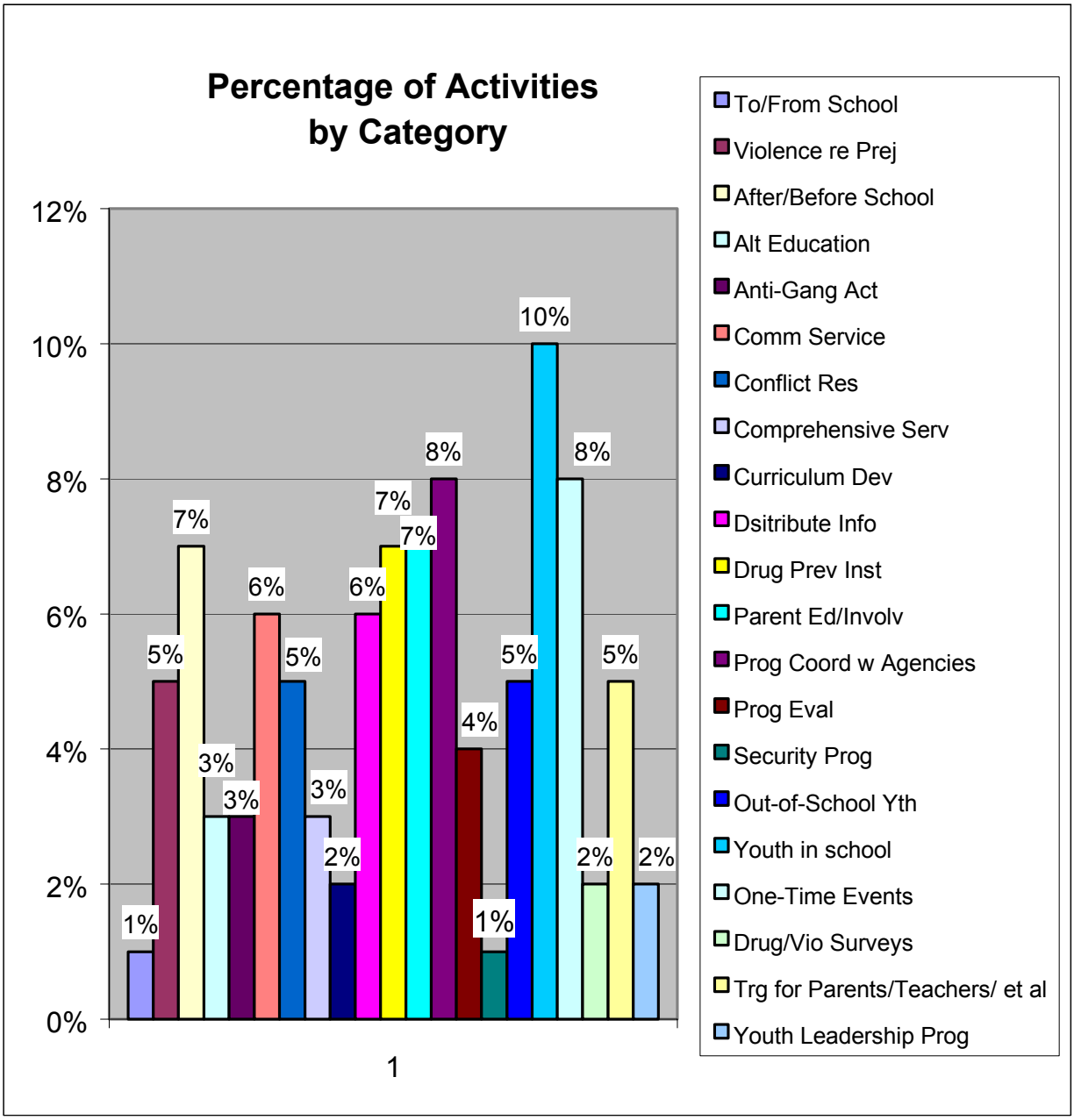
In the Family domain, the two categories that received the most programming were “Family Management Problems (four percent) and Parental Attitudes Favorable to Substance Abuse and Violence (three percent).

In the School Domain, the most frequently addressed risk factor was “Alienation and rebelliousness” (four percent), and “Low School Commitment” (three percent).

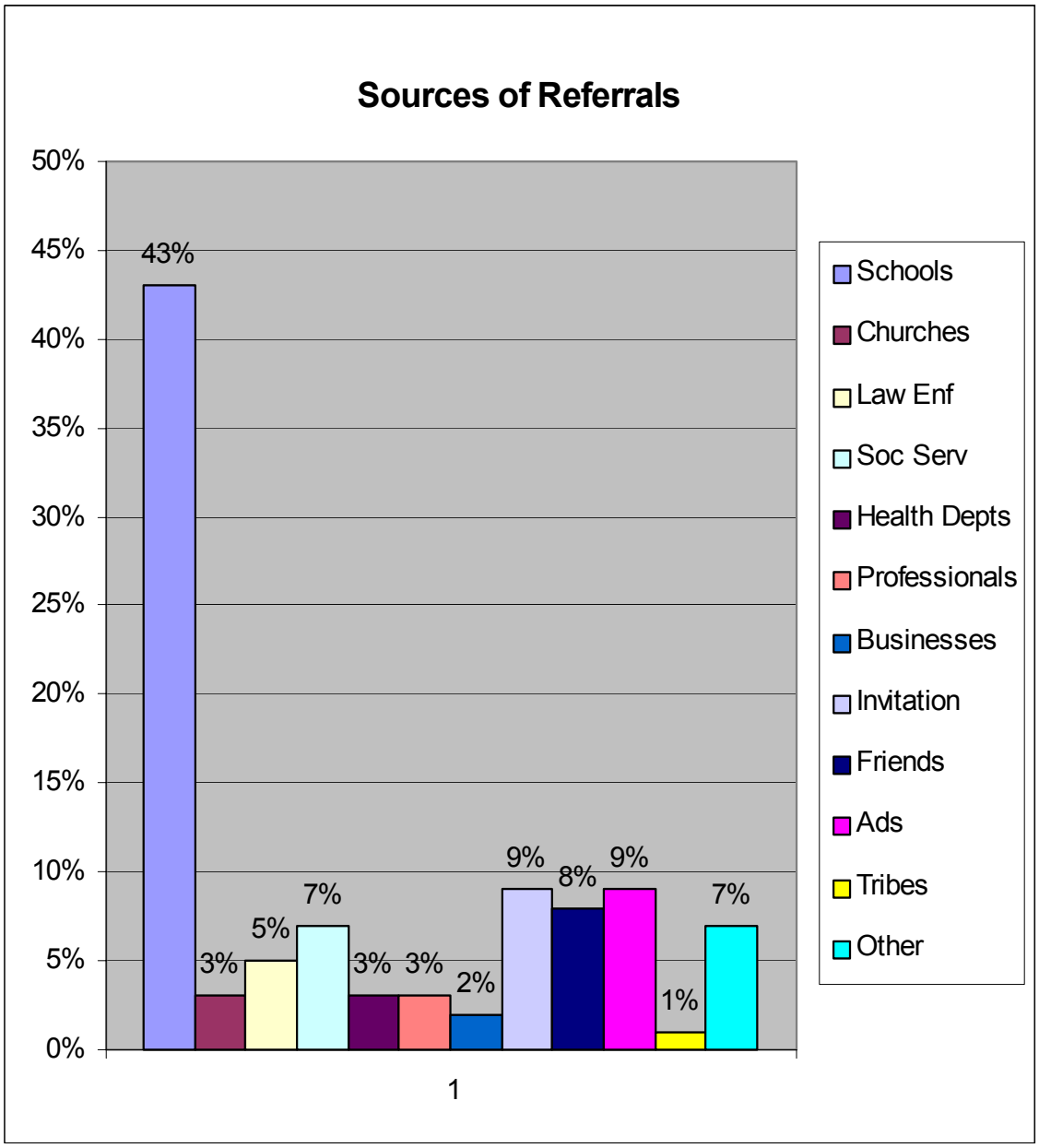
In the Individual/Peer domain, the two most frequently addressed risk factors were “Individual attitudes favorable to substance abuse and violence”(six percent), and “Friends who engage in substance abuse or violence” (five percent).



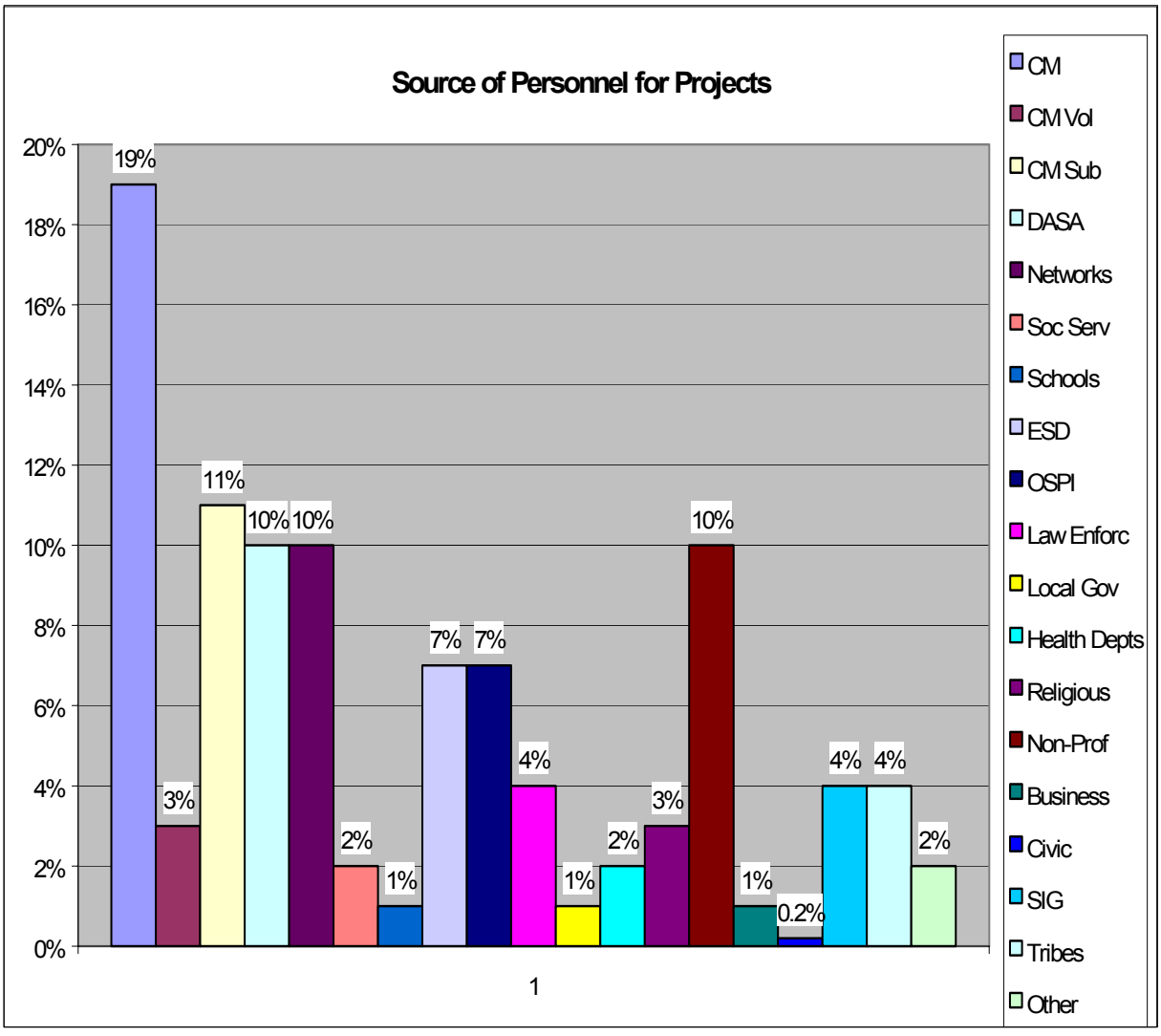
Categories of Service: Of the services and programs provided by CM contractors, the single largest category of programs (10 percent) was programs provided to youth in school. One-time events and programs designed to coordinate services between law enforcement, schools, and other agencies each received eight percent of programming. After/before school programs, Drug Prevention Instruction, and Parent Education and Involvement each accounted for seven percent of total programming. Services which addressed violence resulting from prejudice, conflict resolution/ peer mediation, services to out-of-school youth, and training of parents, teachers, law enforcement, and community members each accounted for another five percent of programming.



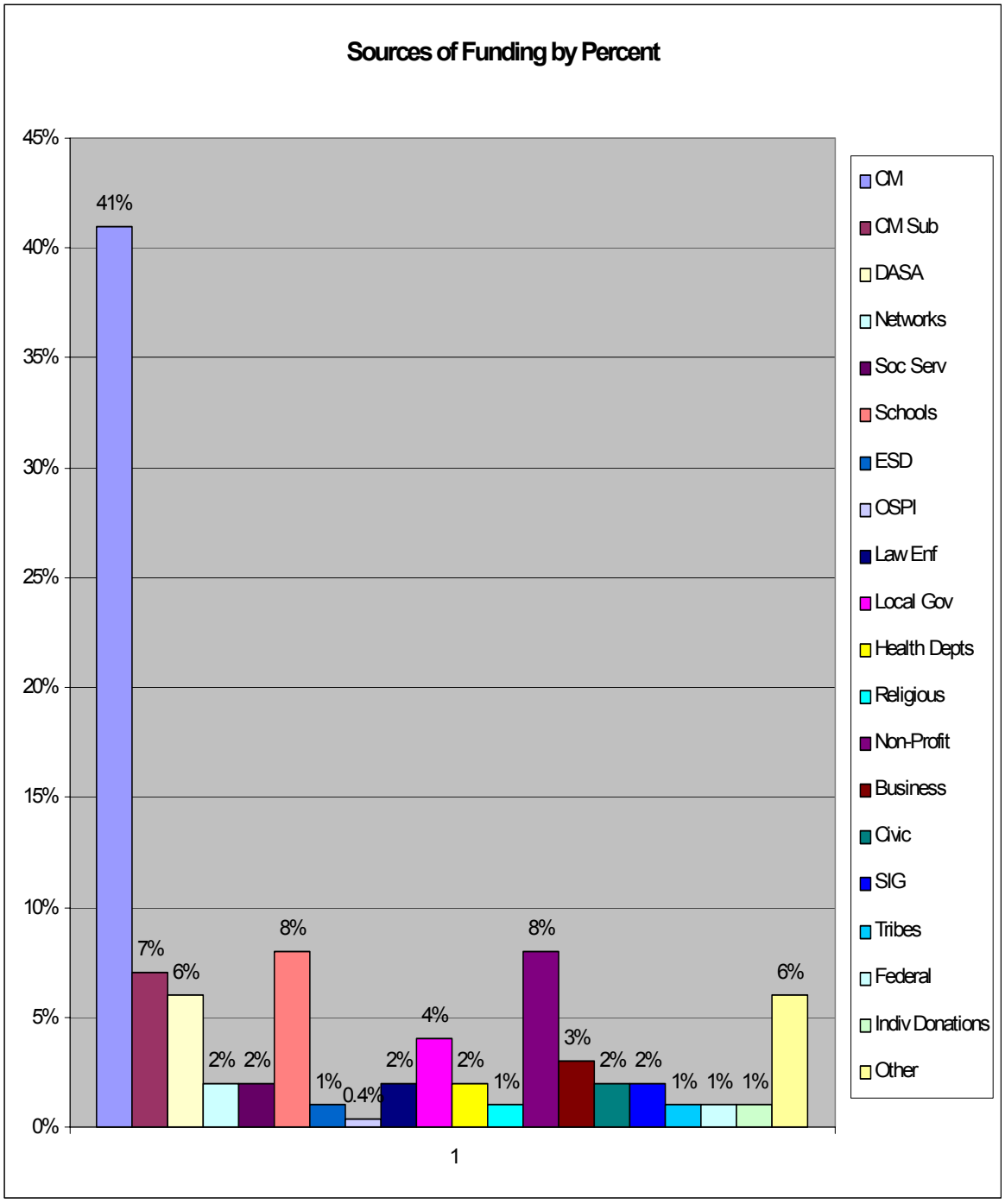
Referrals: Participants were referred to the CM program primarily by schools (43 percent). This is to be expected, since the majority of services and programs are designed for youth (over 51 percent). Ads and invitations from the programs each accounted for 9 percent of the participants. This is significant, since it indicates that participants request services and attend events based upon information they find in their community and their familiarity with CM sponsored services and activities. As was mentioned in the description of the "Network Analysis", a large variety of agencies and organizations are aware of CM services. This chart shows the range of organizations from which referrals are received.



Leveraging and coordinating personnel: CM contractors leverage a significant proportion of both personnel and funding from the community. This can be seen in the two charts related to leveraging: "Sources of Personnel for Projects" and "Sources of Funding by Percentage." CM contractors provide only 19 percent of the personnel providing services and overseeing programs. The most common partners are CM Subcontractors (11 percent), DASA and the Community Networks and local non-profit agencies (each at 10 percent). OSPI and regional ESDs each provide seven percent of the total number of personnel providing services and programs to participants. However, a significant number of volunteers are recruited from religious and civic organizations, private businesses, and non-profit agencies. Other agencies that frequently provide staff for services and activities include the local Health Department, law enforcement, social service agencies, and ethnic groups.

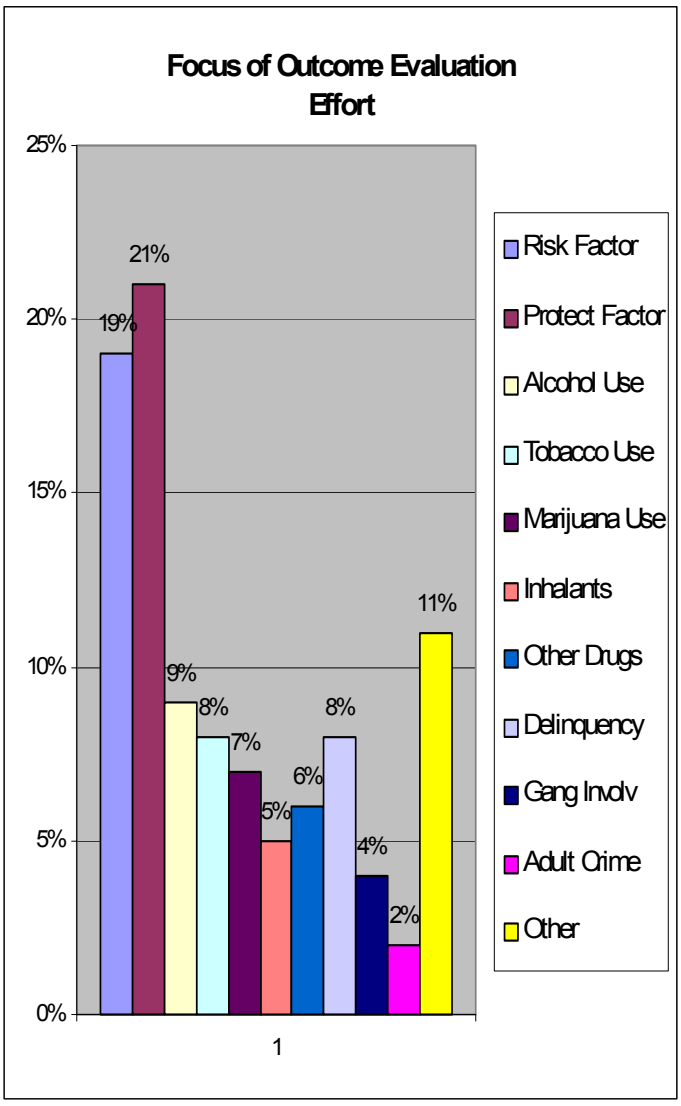


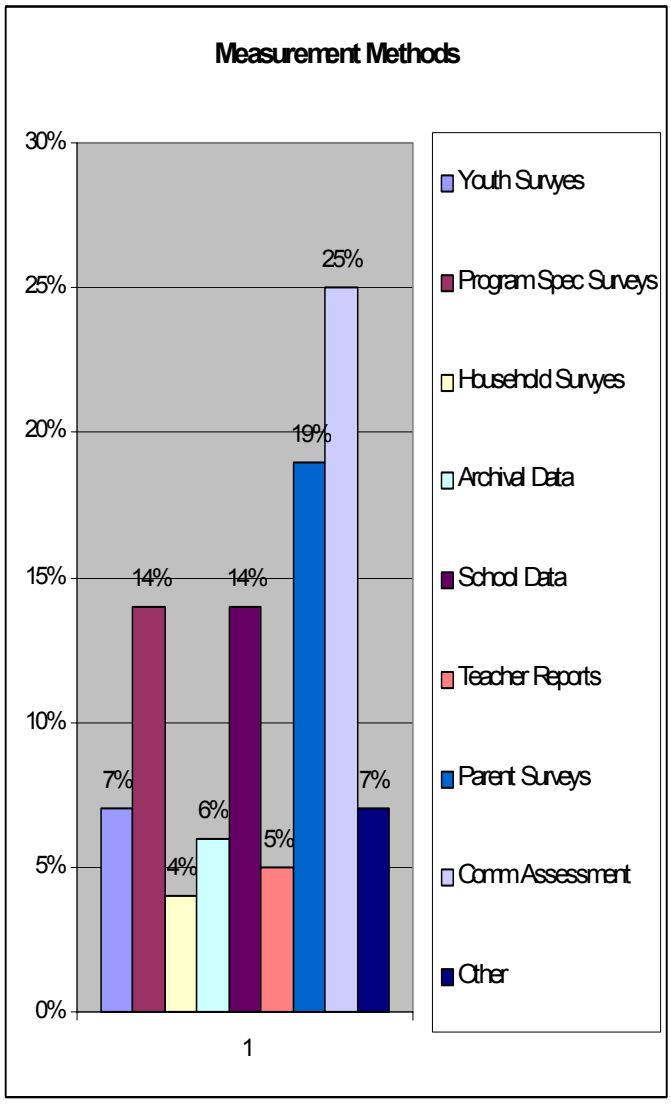
Leveraging and coordinating funding: CM contractors receive less than half their funding from the CM state program (41 percent). If CM Subcontractors' funding is included (at seven percent), the total CM funding still is only 48 percent. This means over half of their funding (52 percent) is leveraged from other sources in the community. Non-profits and schools each account for eight percent of the additional funding. Individual donations and other sources account for a total of seven percent. Another significant source of funding is local governments (cities and counties), which add an additional four percent of the total funding used by CM contractors to provide services and programs.



Outcome Measurement Focus and Methods: CM contractors are required to measure outcomes for their services and programs. The focus of those measurements is primarily the identified risk and or protective factors (19 percent and 21 percent respectively). Measurement focuses unique to the activity were identified in 11percent of the reports, while alcohol (nine percent), tobacco (eight percent), and marijuana use (seven percent) were also identified. Delinquent behavior was also identified in eight percent of the reports.

The most frequent measurement methods used were: community/participant/program assessments and surveys (29 percent), parent surveys (19 percent), school and household/family surveys (each 14 percent) and youth surveys (7 percent).





COMMUNITY MOBILIZATION'S OUTCOME EVALUATION EFFORTS

Outcome evaluation focuses upon what happens as a result of a program or activity. The analysis can examine what has resulted at a specific point during the program, at program completion, or sometime after the program has ended. Outcome evaluations answer questions such as "what has happened as a result of the program after a certain time", "what would have happened if the program had not been available," or "what impacts did the program have upon a system."

The CM Program continues to build on its outcome evaluation efforts. Within their respective funding applications, local CM Coordinators are asked to identify their outcome measurement instruments and provide detailed information concerning the timing of any pre- and post-tests administered to program participants.

The Foundation of CM's Past Outcome Evaluation Efforts

To date, CM has taken several steps to bring the state and local CM Programs to full implementation of an outcome evaluation methodology that is built into the program's day-to-day functioning. The following pages will describe CM's past and current efforts in this direction.

The development of a "CM evaluation model" preceded the implementation of a formal outcome evaluation effort statewide[15]. Earlier efforts had thoroughly investigated CM operations at the county level. Some CM projects encountered difficulties in measuring program outcomes, due to the lack of a local capacity to develop appropriate research designs and the ability to conduct statistical analyses needed for proper outcome evaluation. In response to these concerns, OCD contracted with DRP in the 1998-2000 biennium to develop and implement an outcome-based evaluation among all CM projects. OCD employed the following plan of action:

1. Implementation of pilot outcome evaluations at seven CM sites (1998-99)
2. Delivery of multiple evaluation trainings (1998-2000)
3. Technical assistance to all CM Projects
4. Direct support to all CM sites in implementing their outcome evaluation efforts

The goals of the Pilot were to:

1. Develop and refine technical evaluation knowledge and procedures appropriate in the ongoing field efforts across the state
2. Better understand how evaluation activities, when managed by county-level coordinators, could be effectively implemented
3. Determine what kind of ongoing support would be required to do so

<u>Key Lessons Learned in the Pilot Evaluations</u>

- High quality outcome evaluation is possible within the context of a county-level CM effort.

[15] Developmental Research and Programs, Inc., *Community Mobilization Evaluation, 2001 Final Report,* Channing L. Bete Co., Inc., 2001, p. 50.

- Measurement instruments specifically tailored to each site's evaluation needs either already exist or are being fine-tuned.
- Adequate research designs have been developed for most CM sites.
- The CM sites, without sustained oversight from the state, will often not initiate and sustain the expense and resources needed to conduct their evaluation efforts.

A successful by-product of the effort was the measurement instruments that were developed as a result of the pilot projects. These instruments proved useful in continuing evaluation efforts for the pilot programs and were shared with CM Programs statewide.

Outcome evaluation efforts were initiated at most CM sites in the 1999 – 2000 program year. By year's end, a total of 12 projects reached a stage of completion that supported an individual report on the evaluation's findings. These reports included a short description of the program, the methods of the evaluation, and the findings.

Key Lessons Learned in the 1999 – 2000 Outcome Evaluations

- The number of participants in the evaluation tended to be smaller than expected.
- It is often difficult to maintain the fidelity of the original program model in the ongoing day-to-day program environment.
- The most technical evaluation activities (e.g., statistical analysis) will always require outside support.
- Maintaining a control group in the typical county prevention environment is very difficult to do.

Continuing to Build the CM Program's Outcome Evaluation Capacity

During 2000 – 2001, OCD staff worked closely with the CM Advisory Committee and the local CM Coordinators to determine the future direction of the program's evaluation efforts. It was determined that OCD would shift away from using a contracted evaluation expert (DRP). In May 2001, OCD hired a full-time evaluator on staff. The evaluator's job was to oversee the continuing development and implementation of the CM Program's statewide qualitative (process) and quantitative (outcome) efforts.

CM's Qualitative Evaluation[16]

The new Program Evaluator began a qualitative evaluation of the CM Programs, using in-depth interviewing techniques. One goal of this evaluation effort was to include the perspectives of stakeholders from every county. To do so, 11 Washington State University (WSU) interns were employed to assist with the interviews within the local CM Programs. Evaluators and interns talked to project participants, including children, youth, parents; project staff and administrators; community leaders; and others with an interest in CM. From September through December 2001, a total of 163 CM stakeholders were interviewed in the 39 counties. The interviews focused on:

[16] Daniel M. Amos, Ph.D., *Community Mobilization in Washington State: Preliminary Evaluation Findings,* Office of Community Development, Olympia, WA, 2002.

1. The context for how CM programs functioned within the community's economic, social and political environment.
2. How CM Programs are planned, implemented, and operated.
3. The short- and long-term outcomes of CM projects for participants and communities.

Preliminary Findings of the 2001-2002 Qualitative Evaluation Efforts

CM programs produce positive short- and long-term results that are observable and measurable. Across the state, CM Programs promote healthy families, protect women and children from domestic violence, and provide children and youth with positive alternatives to drugs and violence.

- In one CM community, there were ten out-of-wedlock teenage pregnancies before a CM-funded health education program was implemented. In 2001, two years after this program began, there were only two teenage pregnancies.
- Since 1996, a CM-funded high school/elementary school mentor program in another community grew from 25 participants to more than 200 participants. Outcomes demonstrated that it favorably affected the social and parenting skills of the high school students who were the mentors, the social and academic skills of the grammar school students, and the parenting skills of family members who participated.
- At one elementary school, 81 percent (21 of 26) of the children who received CM one-to-one services improved their learning skills and their scores in regard to aggressiveness, impulsive behavior, anxiousness, and shyness. After adding up all the hours (volunteer and paid) needed to deliver services to children and families, the program at this school cost approximately $3.80 per hour.
- Women who participated in a CM-funded program for victims of domestic violence reported that the program gave them shelter from abusive relationships and helped them learn how to protect themselves and their children.

Future Outcome Evaluation Efforts

The preliminary evaluation results represent only a snapshot of a larger effort by OCD to evaluate the varied and locally based CM Programs. The final evaluation report, which is scheduled for release in August 2002, will include in-depth information from interviews and research conducted by the 11 WSU interns, statistical data from the CM Program Activity Reporting Forms, and quantitative data generated from additional survey tools.

In addition, OCD staff continues to work with the CM Advisory Committee to identify measurement tools appropriate for the local CM Programs. Such tools will be needed to measure the two primary functions of local CM Programs:

1. To *mobilize*, or organize, their local communities
2. To reduce and prevent alcohol, tobacco, other drug abuse, and violence

It is anticipated that tools appropriate to conduct statewide level analysis of both *community organizing activities* and *outcomes of local substance abuse and violence reduction projects* will be identified for use by the local CM Programs as they begin planning their local projects for the 2002 – 2003 program year.

EMERGING ISSUES

Community Mobilization is flexible and is designed to meet the particular needs of each community. While working on many different aspects of drug abuse and violence problems, CM Coordinators have found that new issues are constantly emerging. Often statewide in nature, these emerging issues may be of greater or lesser concern in any given county. CM works to address emerging issues both locally and statewide. State and local agencies often work together to develop a statewide approach. Emerging issues currently faced by CM include:

Collaborative Needs Assessment

As reported earlier, since 1999 CM Contractors have been required to conduct needs assessments to determine the risk and protective factors at work within their communities. To insure that the substance abuse and violence needs with the highest priority are addressed, data used to determine local needs comes from the county profiles developed by DASA, local and statewide archival data, the Washington State Survey of Adolescent Health Behaviors, and local sources.

Some groups proceeded to develop common goals, objectives, and strategies to address the needs identified. It is anticipated that more counties will participate in the collaborative development of goals, objectives, and strategies as future needs assessments are conducted. The CM contractors played a pivotal role in this development and subsequent collaborative efforts.

The SIG evaluation[17] identified the following issues inherent within the needs assessment process:

- Communication from state agencies to their local constituents needs to be strengthened. Agencies' differences in administrative boundaries, fiscal agents, prevention focus, and delivery systems need to be addressed.
- Not all communities wish to engage in a joint needs assessment process.
- There are varying levels of expertise, knowledge and education for gathering and analyzing data.
- It is not always apparent where data can be found, or it may not be readily available (i.e., schools may not wish to release disciplinary action statistics; or crime or drug use statistics may not be readily available for a specific geographical area).
- Local reports that are submitted to state agencies need to be more readily accessible by both state and local staff. The content of data collected should be assessed and adjusted, as necessary, to assure continuing relevance.

Local and Statewide Networking

At the local and state level, CM works to create partnerships with multiple agencies and service providers within and outside of the prevention field. CM facilitates and provides networking capabilities between law enforcement, schools, health departments, DASA, and treatment agencies. CM brings together non-profits, businesses, religious/civic groups, tribal and various ethnic group representatives, and community members to develop strategies to address identified drug and violence prevention needs. CM contractors and state staff work with policy makers to ensure that drug and

[17] Christine Roberts, Ph.D., *Evaluation Report on the Spring 2001 Collaborative Assessment Process,* Washington State Department of Social and Health Services, Olympia, WA, 2001, p. vii.

violence issues are addressed in Washington's communities. The Network Analysis, referenced on page 12, discusses how CM contractors work to develop and maintain active networks of partners who help one another address drug and violence issues. CM is often the catalyst for action in the community. It has been shown that this type of networking requires constant maintenance and assistance in order to thrive. CM contractors prioritize their efforts to ensure that local networking, or *Community Organizing*, receives the support and assistance needed to continue to serve the community. Mobilizing communities and maximizing effective prevention activities are challenging.

- Territorialism: Some organizations want to dominate other agencies' efforts and/or influence the decision-making process to make choices that are contrary to the community's prioritized needs.
- Differing requirements: Expectations of funding sources vary (i.e., Community Networks, DASA, and CM), making it difficult to design comprehensive, inclusive programs. The challenge is to fulfill each funding source's requirements while maximizing each partner's contribution to the whole.
- Resource gaps: Gaps may result from funding limitations and requirements, or from a simple lack of resources. Important activities are weakened due to a lack of needed components (transportation, childcare, etc.). Sometimes the solution requires seeking partners who may fill these gaps. Creativity is necessary in identifying the resources that can respond to the need.

Outcome Measurements

Funding sources expect successful program outcomes. Positive, relevant outcome measures are more easily proven in some fields than in others. In the substance abuse and violence prevention field it is difficult to document outcomes. And since the science of measuring prevention outcomes is new, there is a steep learning curve. Programs at all levels are literally learning and modifying their outcome evaluation approaches as the science is being built.

- Skills development: prevention-program staff requires ongoing training in research methods in order to identify data that should be collected and how to collect it.
- Limited resources: funds used to provide outcome measurement expertise are diverted from serving clients. At what point does a reduction in services become a factor in preventing positive outcomes?
- Barriers encountered: schools may be resistant to releasing attendance, grade, or disciplinary action records.
- Control groups: the purpose of a control group is to demonstrate that a particular program can take credit for the results it produces. Control groups are hard to implement, partly because they are not intended to receive services.
- Prevention: how does a program prove that an individual did not use drugs/commit violence due to participation in a program? We are being asked to document something that did not happen.
- Low participant numbers: in rural communities, programs are often too small to provide a "valid" measurement. Data regarding such participants does not create a statistically meaningful result.

Methamphetamine Impacts

Methamphetamine (meth) production and abuse have been on a steep rise in recent years. Washington State ranks among the top five states nationally in the production of meth. Last year alone, 1,890 meth lab sites were cleaned up in Washington[18]. As a result of the growing meth problem, local CM programs have added projects to address the myriad of meth concerns locally. The emphasis is either on identifying and closing "drug houses," or on raising awareness regarding the harm to the community.

At the request of a number of CM contractors, law enforcement, and environmental agencies in Washington State, Congress funded a statewide *Methamphetamine Initiative* to address the problem from multiple levels. CM contractors in 30 counties will receive funding to create local "Meth Teams" charged with creating countywide comprehensive strategies. Because CM approaches are rooted in community involvement, CM is viewed as having the tools and connections to accomplish the task of creating and sustaining such teams. The 30 CM Contractors will be co-conveners with their county sheriff for their county's team, and will address issues including:

- Methamphetamine labs or manufacturing facilities are growing at a rate faster than enforcing agencies can deal with them.
- Meth manufacturers have begun to move into more remote areas of the state in order to avoid detection.
- Meth manufacturers are using more creative and portable sites for production (e.g. storage units, trailers, cars, highway rest stops, etc.).
- One pound of methamphetamine product creates up to ten pounds of highly toxic refuse that is abandoned, dumped on the ground, poured into streams or sewers, or dumped down wells.
- The cost of locating, breaking down, and cleaning up meth labs far exceeds available resources.
- Meth is being widely distributed. It has gained in popularity, and education about its dangers lags far behind its availability and the promotion of its use.
- Meth addiction, while difficult, is treatable. Relapse among users in treatment is an issue at the forefront of addiction.
- During the 2000-2001 year, agencies that address the various aspects of meth issues were not yet been mobilized into integrated teams.

Inadequate and Unstable Funding

Prevention funding is unstable and, therefore, inadequate to provide a meaningful impact. CM funding has been steadily reduced over the last seven years. Prevention providers face the reality that funding may not continue. Programs and projects that are built on short-term funding cannot provide long-term results. Prevention activity results often emerge after several years of services. When programs cannot insure their existence for more than one to two years at a time, strategies must be short-term.

- Territorialism created by competition with other prevention programs for funding undermines cooperation/collaboration attempts.

[18] *1999, 2000 and 2001 Meth Labs/ Dumps,* Washington State Department of Ecology, Olympia, WA, 2002.

- Leaving a majority of clients un-served due to lack of funds leaves problems un-addressed within the community and makes it difficult to show progress.
- In many communities, the need for service is growing faster than the resources.
- Demands placed on local CM programs to effectively demonstrate success divert resources from direct service to administrative functions. This results in staff burnout and turnover within the prevention field.
- CM programs are consistently expected to do more with less.